Tri County Internal Medicine, P.C.
Request for Release of Protected Health Information (PHI)

If you wish to have any of your protected health information released to any family members or friends, then you must list those individuals on this form. **WE CANNOT SPEAK TO ANYONE ABOUT YOUR PROTECTED HEALTH INFORMATION IF THEY ARE NOT LISTED ON THIS FORM.** You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.
*****PLEASE NOTE:** Tri County Internal Medicine, P.C. is not required to agree to your request. Please see our Notice of Privacy Practices for more information regarding such requests.

Patient's Name: _____ **Date of Birth**: _____

May we call, text, or email you appointment information? ☐ Yes ☐No

May we leave a detailed message on your voicemail? ☐ Yes ☐No

May we discuss your Protected Health Information (such as test results, prescription information, appointment information, referral information, medical diagnoses, billing information, etc.) with anyone besides you?

☐ Yes ☐No

If you answered yes, please list those individuals below:

Name: _____ Relationship to Patient: _____ Phone Number: _____
May we leave a detailed message on their voicemail? ☐ Yes ☐No

Name: _____ Relationship to Patient: _____ Phone Number: _____
May we leave a detailed message on their voicemail? ☐ Yes ☐No

Name: _____ Relationship to Patient: _____ Phone Number: _____
May we leave a detailed message on their voicemail? ☐ Yes ☐No

Name: _____ Relationship to Patient: _____ Phone Number: _____
May we leave a detailed message on their voicemail? ☐ Yes ☐No

Signature of Patient: _____ **Date:** _____
(or signature of Legal Guardian if patient is a minor or an incapacitated adult)